State of California—Health and Human Services Agency

ATTACHMENT III.4
Department of Health Services

PAS/PASARR LEVEL I SCREENING DOCUMENT

Federal Law prohibits payment for nursing facility services until PAS/PASARR screening has been done. This screening must be completed before or on the date of admission or payment cannot be made for care provided. Please complete all sections of this form that apply except for those marked FOR STATE USE ONLY.

SEE INSTRUCTIONS ON REVERSE SIDE.
SECTIONS I THROUGH VII MUST BE COMPLETED.

☐ Prescreen
☐ Status Change

Please print or type.

I. Client Data

1. Name—Last | First | Middle initial

2. Medi-Cal ID number:

3. Date of Birth: M M D D Y Y Y Y

4. Date of Last Physical Examination: M M D D Y Y Y Y

5. Primary diagnosis for admission to NF:

LEVEL I EVALUATION

II. Why Community Placement is Not an Option
(Check all that apply.)

6. ☐ Change in medical, mental, and physical functioning capability
7. ☐ Caregiver unavailable
8. ☐ Community resources unavailable
9. ☐ Client or family choice

III. Identifying Criteria for Mental Illness
(Answer yes or no to all questions.)

10. ☐ Yes ☐ No MI diagnosis (excluding dementia)
If yes, describe: _____

11. Serious difficulty within the past 3–6 months in any one of the following as a result of MI:
a. ☐ Yes ☐ No Interpersonal functioning
b. ☐ Yes ☐ No Concentration, persistence, pace
c. ☐ Yes ☐ No Adaptation to change

12. Experienced one of the following within past two years:
a. ☐ Yes ☐ No Hospitalization for psychiatric treatment
b. ☐ Yes ☐ No Serious disruption—treatment/supportive Services

13. ☐ Yes ☐ No Referred by County Mental Health

IV. Identifying Criteria for Developmental Disability
(Answer yes or no to each question.)

14. ☐ Yes ☐ No MR diagnosis: _____

15. History of MR/developmental disability?
☐ Yes ☐ No Describe: _____

16. Any presenting evidence to indicate MR?
☐ Yes ☐ No Describe: _____

17. Referred by regional center?
☐ Yes ☐ No

V. Level II Referral Data
(Referral should be mailed within five working days of evaluation.)

18. Referral date: _____

17. a. ☐ DMH referral required if number 10 shows an MI diagnosis and numbers 11–12 are *both* answered with at least one yes answer.
b. ☐ DDS referral required if any *one* of numbers 14–17 are answered yes.
c. ☐ No referral necessary.

VI. Form Completion

Form completed by: _____
Date of completion: _____
Representing facility: _____
Telephone number: _____ Extension: _____

VII. Receiving Facility

Receiving facility: _____
Address: _____
_____ ZIP code _____
Telephone number: _____ Extension _____
FAX number: _____
Admission date: _____

VIII. DMH Use Only

Override: _____
Date received: _____
Facility number: _____
County number: _____
Contractor number: _____

IX. DDS Use Only

RC name: _____
UCI: _____
Date: _____
Status: _____
Disposition: _____

X. Level II Completion

Name: _____
Title: _____
Date: _____
Determination: _____

XI. Annual Resident Review

Name: _____
Title: _____
Date: _____
Determination: _____

XII. Annual Resident Review

Name: _____
Title: _____
Date: _____
Determination: _____

XIII. Annual Resident Review

Name: _____
Title: _____
Date: _____
Dtermination: _____